accurate figures, but of forty cases, five ceased to be subject to alternation in old age after sixty, one being after eighty, two being women, and the men all left in a condition of mind and brain that might be legally reckoned insanity, though in all cases there were some mental enfeeblement and a tendency to be easily upset, lethargy, and a want of spontaneity and volitional power. Another case terminated in complete dementia. Two died of exhaustion during a maniacal period. Three things are sure about the prognosis: 1, its utter uncertainty; 2, recovery cannot be looked for at the climacteric period in many cases; 3, about twenty per cent. may be expected to settle down into a sort of quiet, comfortable, slightly enfeebled condition in the senile period of life. Very few indeed become completely demented, though two have run on into chronic mania. The tendency to death is very slight. Dr. Clouston found on autopsy the usual secondary changes consequent upon fluxionary conditions, and regards the psychosis as one dependent on dynamic or bio-chemical changes.

RESTRAINT AND SECLUSION.—Dr. C. H. Nichols (*New York Medical Journal*, March 31, 1883) believes that neither mechanical restraint nor seclusion should ever be resorted to unless, in the opinion of a competent and responsible medical officer, protection in particular cases against violence, exhaustive activity, the removal of surgical dressings, etc., can be effected more easily, completely, and beneficially to the patient than by either the hands of attendants, medicinal agents, showers and douches (inadmissible except in a very limited number of cases), or "packs," wet or dry, obviously a very positive form of mechanical restraint, though their therapeutical advantages may now and then be superior to any substitute for them; but that it is the practitioner's duty to resort to mechanical restraint or seclusion whenever it is needed for the reasons stated. The actual practice in the use of restraint varies more or less in different institutions, and is governed, as other measures of treatment are, by the training and character of the medical officers in charge, the opinion and support of the trustees, the number and character of the patients with respect to the extent and quality of their accommodations, the proportion of attendants to patients, the scale of expenditure, and other agencies of treatment. The restraint needed in any institution will vary greatly with the varying conditions of the patients. While entirely unwilling to be governed by a prohibitory dogma or an arbitrary proportion to patients in the use of restraint, Dr. Nichols is of the opinion that only exceptional circumstances justify its average use in more than two or three per cent. of the cases under treatment. The effort was made last year to see how far restraint or seclusion could be reduced without violating the principles laid down, and on the men's side of the house restraint with the camisole or the bed-strap, or by seclusion, was resorted to in the course of the year in only eleven different cases (once in three

cases, three times in two cases, four times in two cases, five times in two cases, six times in one case, and seven times in one case, for periods varying from one to twelve hours). On the women's side of the house more restraint was used in the early part of the year, but in the last seven months it was used in only two cases, three times in one case, and four times in the other, for periods varying from one to ten hours. In the foregoing list of restraint used is included seclusion in three different cases of paroxysmal mania in men and one of general paralysis (four times in two cases, five times in one case, and once in one case, for periods varying from two to six hours). Seclusion was not resorted to in any other case, and the habit of voluntary seclusion into which certain old patients are inclined to fall has been entirely broken up. It is distinctly stated that the reduced use of restraint has not been attended by an increased use of nervous sedatives or hypnotics, which have, in fact, been very sparingly used. On the contrary, more dependence than ever before has been placed upon the composing and indirect hypnotic effects of tonic and stimulant treatment and the use of warm medicated baths and massage at bedtime. This illustrates the beneficial results of the New York Neurological Society's criticism. At the same time, it is evidence that Dr. Nichols is not a doctrinaire, and is incapable of the deception put upon Dr. Bucknill.

MUTILATIONS BY SEXUAL LUNATICS.—The relations between religiosity, sexuality, and mutilation have long been recognized by alienists. An aberrant tendency of the religio-sexual order finds its expression in some religious sects, and this tendency to self-mutilation is one of the cardinal principles of the Skoptzki, a Russian sect. Examples of the kind of mutilation practised by this sect are by no means unfrequently reported as occurring among religious lunatics. The *Archives de Neurologie*, September, 1882, reports the case of a tailor who removed both testicles without any other instrument than his nails, and perfectly recovered from the injury. In another case, reported in *Langenbeck's Archives*, a similar sexo-religious lunatic opened his abdomen with a rusty penknife; then, having recovered, he removed the left testicle and subsequently the right. It would appear that in certain cases, as was remarked by Montaigne, lust finds zest and stimulation in pain, and this seeking for a pain as a stimulus is, it is by no means improbable, an atavism, as certain of the lower animals cannot copulate without pain. In many of these religious lunatics the mutilation is referred to remorse or a desire to avoid temptation, but the most probable explanation is, in many cases, that of Montaigne.

PROGRESSIVE PARESIS AND MULTIPLE CEREBRO-SPINAL SCLEROSIS. — Zacher (*Archiv für Psychiatrie*, Band xiii) reports a